INDIANA HEALTH COVERAGE PROGRAMS

Resolution of Claim Errors Operating Procedures Manual

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Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	June 2000	Multiple	Package C updates	Deanna Daeger
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Section 1: Introduction

Overview

The Indiana Family and Social Services Administration (IFSSA) is the umbrella agency responsible for administering most of Indiana's public assistance programs. The secretary of the IFSSA reports to the governor's executive assistant of Health and Human Services.

The Indiana Health Coverage Programs (IHCP) provides medical assistance to more than 400,000 eligible members. This includes the categorically needy population such as those individuals eligible for or receiving federal financial assistance, those deemed categorically needy, or those eligible for services under federally authorized waiver programs. In addition, limited IHCP benefits are available to certain population groups.

Goals and Objectives

The purpose of this manual is to describe the day to day procedures of the Resolutions Unit. It is also used in training employees and as a reference tool.

The goals of the Resolutions Unit are to cooperate and work as a team, remain knowledgeable about processing standards, develop and retain the most outstanding people, and to keep the lines of communication open within the unit, as well as with other departments. Another goal of the unit is to keep suspense at a daily average of 7,000 errors with less than six percent of that volume being 25 to 30 days old. Less than one percent of electronic claims should be older than 21 days, and less than one percent of paper claims should be older than 30 days. Another goal is to zero out the daily suspense inventory. The examiners must also maintain an accuracy rate of 97 percent and process a minimum of 120 claims per hour.

The primary objective of the Resolutions Unit is to correctly adjudicate all suspended claims within thirty days. Claims suspending in locations *22, 30,* and *31* are processed by Health Care Excel.

Section 2: Department Organization and Staffing

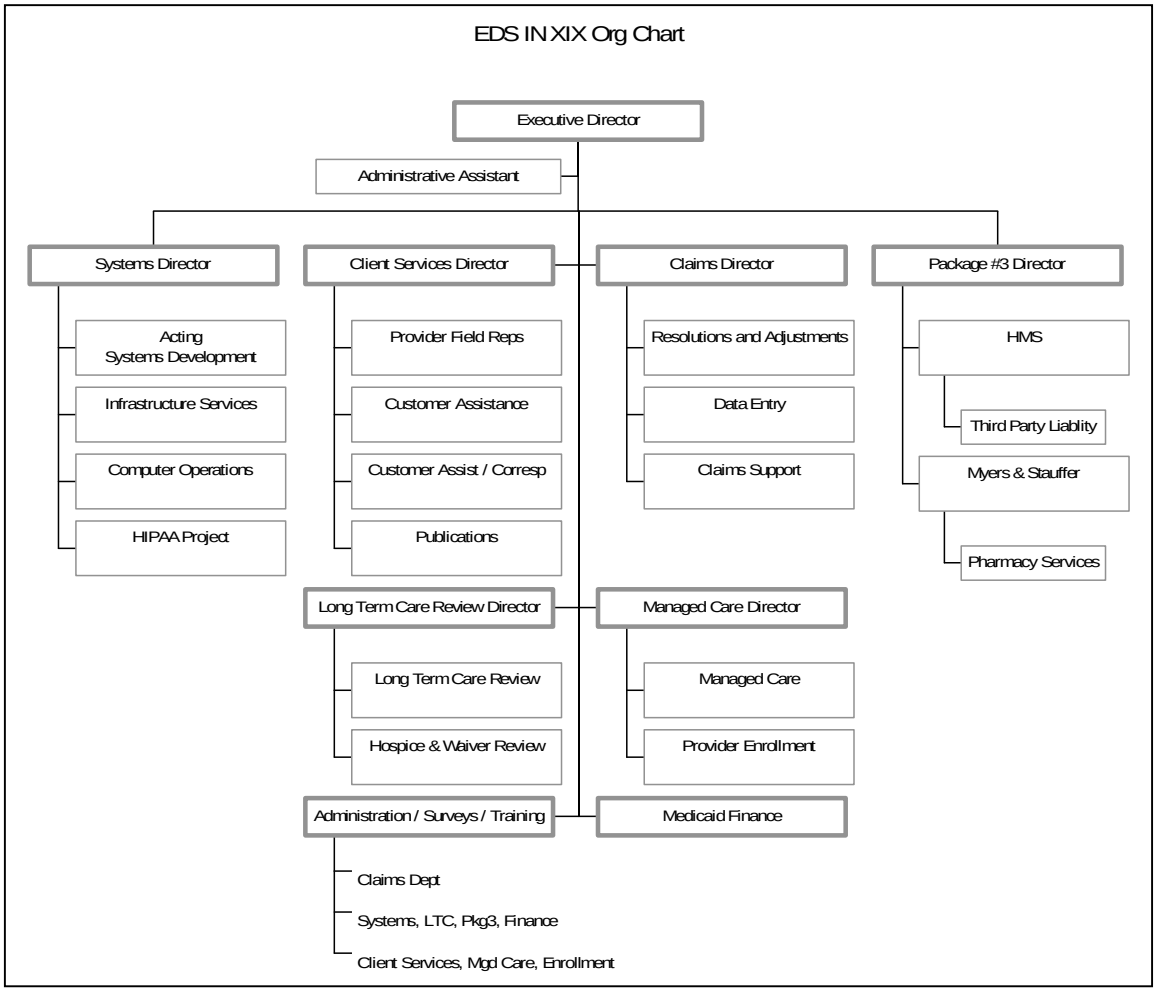

Figure 2.1 – Account Organization and Staffing

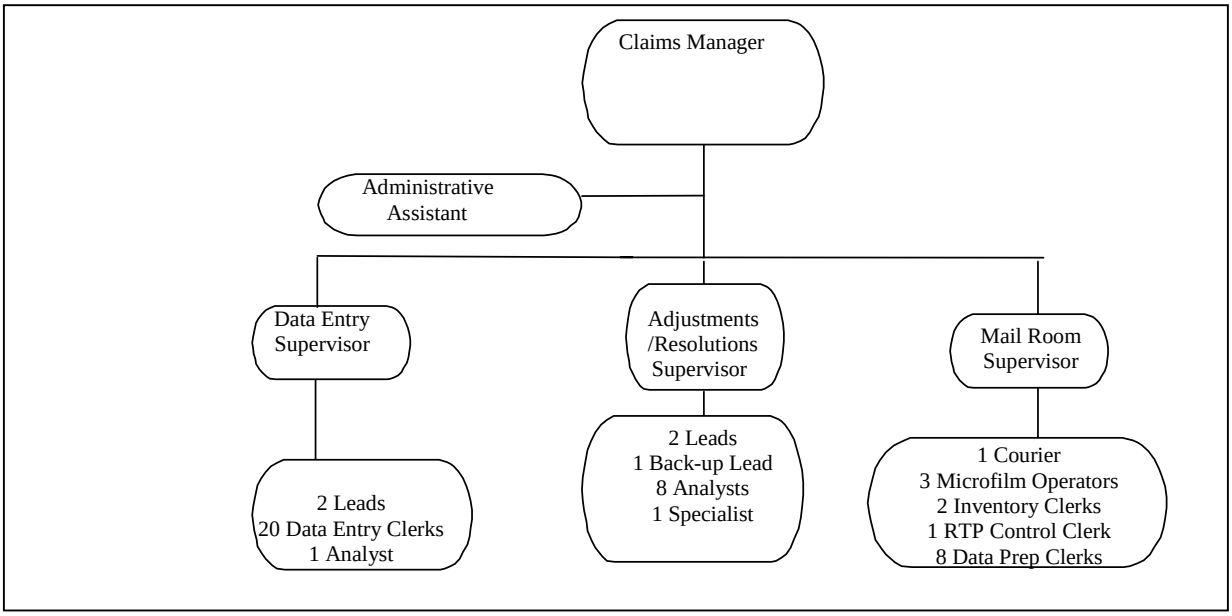

Figure 2.2 – Claims Department Organization

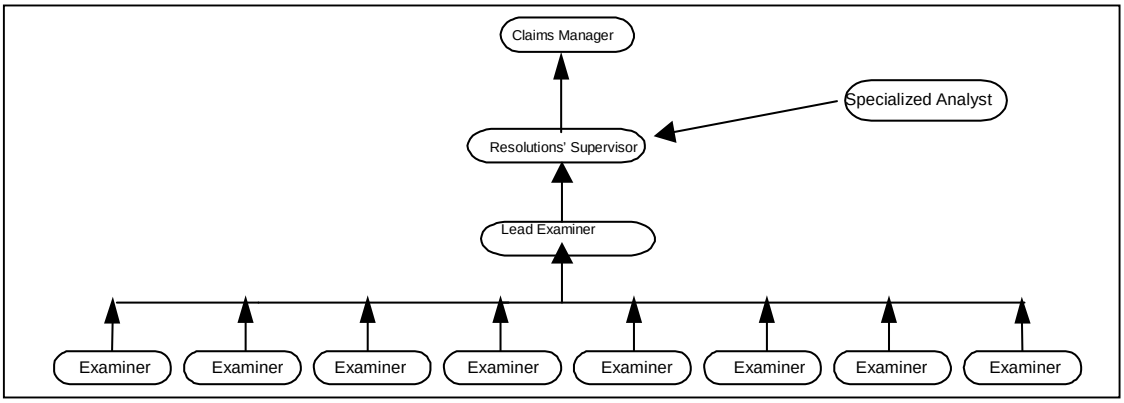

Figure 2.3 – Resolutions Unit Organization

Resolutions Supervisor

The Resolutions Unit supervisor is responsible for the day-to-day operations of the unit. This includes preparing and maintaining detail reports of claim suspense activity and being responsible for all examiners and clerks in the unit. The unit supervisor also monitors each individual's performance to ensure that quality and production standards are maintained. The supervisor serves as liaison between other departments within the account and IFSSA. Furthermore, it is the unit supervisor's responsibility to ensure that the Resolutions Unit's contractual obligations are met.

Claims Specialized Quality Analyst

The quality analyst is responsible for handling special projects and research for the OMPP and the Claims Resolution Unit. The quality analyst is also responsible for updating the monthly contract monitoring (CM) report after each unit within the department updates their statistics. The quality analyst provides training to the Adjustment/Resolution Unit as a result of policy changes, processing changes, or updates. The quality analyst is lead analyst for the claims processing assessment system (CPAS) team and is responsible for maintaining action item logs for the team, providing computer output to laser disk (COLD) reports to the team for review of the claims, and updating the monthly report for the team. The quality analyst is also responsible for supporting action teams, attending walkthroughs, and providing feedback about provider manuals as assigned.

Lead Resolutions Examiner

This individual is responsible for the reassignment of work to other examiners, assigning priority batches, monitoring the workflow schedule, performing quality checks on current employees, providing ongoing training in the unit, and training new employees. The lead examiner also acts as the unit supervisor's back up and as a specialized resolutions analyst.

Resolutions Examiner

The examiner's responsibilities include processing suspended claims in accordance with established guidelines, processing returned Claim Correction Forms (CCFs), notifying the lead examiner of any problem

claims, copying and maintaining state mandated claim information, and remaining knowledgeable about processing procedures.

Section 3: Work Flow Procedures

Overview

During the claims adjudication process, any claims that fail an edit or audit will generate a CCF, systematically deny, systematically cutback, or suspend. The error disposition has been set on the Error Disposition Table. A suspended claim means that processing is suspended until the error causing the failure is reviewed, corrected, or otherwise resolved.

The process of reviewing, correcting, and resolving claim errors is performed in the Resolutions, Surveillance and Utilization Review (SUR) or Adjustments Units. The examiners in these units follow written guidelines when adjudicating claims that fail defined edits or audits.

Batch Pulling Process

Printing Scheduler

Resolutions clerks must print their scheduler and put it in the batch clerk's basket by the following designated times:

Table 3.1 – Resolutions Clerk Responsibilities

Time	Instructions
8 a.m.	Duplicates must be processed first, if there are any, to meet the 8 a.m. deadline. Clerks who arrive at 7:45 a.m. have until 8:15 a.m. if working duplicates first.
Noon	This deadline includes everyone. After printing the scheduler, it is the responsibility of the Resolutions clerk to cross out the batches on the print that the clerk has on his or her desk. This saves time for the batch clerk.

Note: The exception is that the Resolutions specialist will not always make the 8 a.m. deadline due to other commitments, but must make the noon deadline.

Pulling Batches

The batch clerk pulls all aged claims first. If the batch clerk is unable to find a batch, the supervisor or specialist must be notified. It is also the batch clerk's responsibility to check off any batch found on the scheduler to prevent someone else from looking for the batch a second time. The batch clerk has one hour to pull all of the batches.

Pulling Microfilm Claims

Old claims that must be pulled off microfilm are given to the Claims Support supervisor on Monday morning. This allows time to research the claim. The Resolutions staff must follow up on these claims daily to ensure they are processed.

Claims Processing Steps

1. Individual claims wait for initiation.
2. Internal control number (ICN) is converted into RR YYJJJ BBB SSS L.

Table 3.2 – Explanation of ICN Codes

Code	Description
RR	Region Code
YY	2-digit year indicator
JJJ	3-digit Julian date
BBB	3-digit batch indicator
SSS	3-digit sequence indicator
L	1-digit line number for Drug claims

3. Claim elements are formatted and placed in the database.
4. Claims activation verified.
5. Claims are edited for simple field presence, format, data compatibility, and balancing.
6. Claims that fail the field edits are suspended, denied, or a CCF is generated as applicable.
7. Claims are subjected to provider edits.
8. Claims that fail the provider edits are suspended, denied, or a CCF is generated as applicable.
9. Claims are subjected to member edits.

10. Claims that fail recipient edits are suspended, denied, or a CCF is generated as applicable.
11. Claims are subjected to the Prior Authorization (PA), Reference, and SUR edits.
12. Claims that fail the PA, Reference, and SUR edits are suspended, denied, or a CCF is generated as applicable.
13. Claims are priced.
14. Claims that cannot be priced are suspended for manual pricing.
15. Clean claims are dup-checked.
16. Claims that fail the dup-check suspend or deny.
17. Clean claims are audited (*History* and *Medical Policy*).
18. Claims that fail the audits are suspended, denied, or a CCF is generated as applicable.
19. Clean claims are placed in *approved to pay* status.
20. Claims, provider, recipient, and PA databases are updated with claims information.

Suspended Claims Location

Claims that fail an edit or audit are routed to a suspense location. Depending on the edit or audit that caused the failure, a claim is routed to a claim location that identifies the type of edit or audit that failed. Location codes are assigned to specific departments in Indiana*AIM*. Each department is responsible for resolving claim errors and edit or audit failures. Suspended Claims Location (SCL) is determined by region codes or edit and audit failure hierarchy. Adjustments failing any edit or audit are routed to the Adjustments Unit location. Medical policy edit and audit failures are routed to the Medical Policy Unit location. Claims that fail *Lock-In* and *Suspect Provider* edits are routed to the SUR Unit, and the remaining edit or audit failures are routed to the Suspense Resolutions Unit. In cases of disposition conflicts, the claims are routed to the Suspense Resolutions Unit. The suspense locations are described in Table 3.3.

Table 3.3 – Suspense Locations

Location Code	Description
00	Validity edits
01	Provider related edits
02	Recipient related edits
03	PA related edits
04	Procedure code related edits
20	History related audits (dup audits)
21	Medical policy related edits and audits
22	Medical review
23	Special Manual Pricing
30	SUR Provider Edits
31	SUR Recipient Edits
40	CCF
41	Recycle
42	Hold
43	IFSSA
44	CSHCS
50	Adjustments
66	Claim denied
98	Claim approved for payment
99	Claim paid

Table 3.4 – Region Codes

Region Code	Description
10	Paper
11	Paper with attachment
12	CCF
20	Electronic
22	Shadow (Encounter Claims)
23	Electronic Crossover Claims using PES
25	Point of Service (POS)
40	Converted Claims
41	Converted 590 Claims
45	Converted Adjustments
46	Converted 590 Adjustments
50	Non-check related Adjustments
51	Check related Adjustments
54	Mass Adjustments - Void transactions
55	Mass Adjustment - Retro rate
56	Mass Adjustments
57	Adjustments reprocessed by EDS systems engineers
58	Open
59	Open
60	Non-claim specific financial transactions
70	HMO capitation
80	Claims reprocessed by EDS systems engineers
90	Special Projects - State Claims

Handling of the Aged Reports

1. The resolutions clerk prints off age reports *CTL0130D* and *CTL0152D.*
2. The resolutions clerk reviews the report for locations *00-21* and *23.*
3. If there are any *00-21* and *23* locations over 30 days, the resolutions clerk highlights the ICN.

4. After review the resolutions clerk gives the reports to the team lead.
5. The team lead reviews the report. If there are any highlighted ICNs, the team lead looks up the ICNs in IndianaAIM to see why the claims were not worked.
6. The team lead then gives the reports to the supervisor. If there are any highlighted ICNs on the report, the team lead provides an explanation of the highlighted ICNs for the supervisor.
7. The supervisor reviews the reports for accuracy.

The following is an example of aged report *CTD-0130-D*:

Report	CTL-0130-D	Indiana*AIM*	Run Date		01/04/2002	
Process	AGED CLAIMS LISTING			Page No	1	
Location						
CT ICN	RID	BILL PROV	ELSP	LOC CD	LOC DT	DAYS LOC
M1101274759620	100493951699	100194330	95	30	20011010	86
M1101274760190	101800932299	100194330	95	30	20011022	74
M1101274760210	102910298399	100194330	95	30	20011025	71
M1101278763270	100516330699	100194330	91	30	20011015	81
M1101278766970	100588349999	100194330	91	30	20011024	72
M1101278766990	100084140199	100194330	91	30	20011024	72
M1101285759130	101372053599	100194330	84	30	20011031	65
M1101285759140	100120698499	100194330	84	30	20011022	74
M1101285759160	103012892899	100194330	84	30	20011031	65
M1101285759180	102665973899	100194330	84	30	20011022	74
M1101285759190	102373897299	100194330	84	30	20011031	65
M1101285759220	101920091299	100194330	84	30	20011031	65
M1101285759230	102607507599	100194330	84	30	20011031	65
M1101285759330	100085058499	100194330	84	30	20011022	74
M1101285760540	100202178899	100194330	84	30	20011102	63

Scheduling and Reassigning Claims

Scheduling

Members are entered into the system based on their work location. The system pulls all suspended claims not assigned to a user. The system assigns up to 2000 claims with 500 claims per claim type (for example: 500 physician, 500 dental, 500 pharmacy and 500 UB-92).

There may not be 500 claims per claim type to load daily. For example; 200 physician claims suspend for *location 22*, user one will receive these claims. If 700 physician claims suspend then user one will receive 500 claims and user two will receive 200 claims. The scheduler will be run by EDS staff every day.

Reassigning Claims

Claims can be reassigned from one user to another user. For example; if user one is absent for a day then user one's claims can be reassigned to user two. To reassign a claim it is necessary to know both of the user's IDs. The claims can be reassigned to a user or sections of the claim can be reassigned to that particular section. To reassign the entire claim enter the claim type (physician, dental, pharmacy, or UB-92), the status (suspended), and the user name. Click **Search** to locate the suspended claims. To re-assign claims, perform the following steps:

1. Sign on to IndianaAIM.
2. Click **Options**, then click **Re-assign Claims**.
3. Type the user name the claims are coming from in the **Search For ID** field and type the new user to assign the claims to in the **Change To ID** field.
4. Click **OK**.
5. Verify that the user ID changes to reflect the newly assigned user.
6. Click **Save** to transfer the claim.

To assign just a few claims between users, follow the above steps to locate suspended claims for the desired users. Then click on the user ID name (located on the screen with the ICN, claim type, user ID and status in a row) and change this ID to the new user.

Work Scheduling and Assignment

The claims routed to the different location codes are listed in order by age on the daily Suspense Processing Scheduler. The examiners in the Suspense Processing Unit are given certain criteria, depending on each examiner's expertise. Claims processing criteria are determined and assigned by the manager, supervisor, or lead staff of each Suspense Processing Unit. Examiners are given a standard package to start with and are granted more authority as they become more knowledgeable about claims processing. As the claims are processed, more claims are

given to the examiner on an as needed basis. This is done by the lead staff or supervisor.

Age Calculation

After the scheduler is run the team lead will locate and print the Julian dates for the week from Indiana*AIM*. The team lead also assigns any scheduled claims to the resolution clerk. The total number of claims is counted and the total is given to the Resolutions supervisor and the Claims director.

Suspense Processing

Suspended claims are displayed to examiners in a format similar to the claim form. The error code, along with an English definition is also displayed. The screen provides the examiners with a field that applies claims processing transactions, claim location, or explanation of benefits (EOB) messages for claim denials. The screen allows examiners to access various reference files necessary to effectively process suspended claims. When processing suspended claims, examiners have the option of applying the following transactions to a claim, depending on the edit or audit failure:

- **Add/Change -** The examiners have the ability to add or change data on the claim to correct keying errors, or to enter additional data from CCFs returned by providers.
- **Force/Override** - Some edits and audits can be overridden to force the claim to go through the claims processing cycle.
- **Deny** - The claim can be denied if warranted and called for by the edit or audit. In denying a claim, the examiner has the option to generate just the EOB related to the edit or audit failed or to add a more detailed EOB to explain the reason the claim denied.
- **CCF Generation** - The system generates a CCF for the provider that allows the provider to change any incorrect fields on the claim.
- **Recycle** - The claim may be recycled. This transaction can be applied if the claim failed an edit or audit that was set in error and has since been corrected.
- **Route** - The claim can be routed to a different claim location. This allows a less experienced examiner to route the claim to a more knowledgeable examiner or unit for proper handling.
- **Hold** - The claim can be held in a specified claim location. This transaction is used to postpone the adjudication of a claim pending

resolution of any problems that prevent the claim from being processed properly, such as system problems or pending policy decisions.

Suspended claims display all error codes that caused the claim to suspend, up to a maximum of 20 error codes. After the examiner has cleared all error codes applicable to the claim location, the claim is routed to the next applicable location code if there are other errors that need correction. If no other errors exist, the claim is resubmitted to the processing system and is again subjected to all edits and audits. Overrides applied to any errors are captured to avoid having the claim suspend again for the same errors. These overrides stay with the history of the claim record.

Special Batching

Introduction

The purpose of this section is to explain the proper procedure for submitting special batches. This section will also explain how to prepare special batches, the process time required, expectations from the submitter, quality checks, follow-up, where to submit special batches, how to identify batch processors, and the batch processor's role in this process. All special batches must include the required forms with the batch for processing. The forms used to process special batches are available electronically.

When processing batches internally, personnel often inquire which claim needs to be processed as a special batch versus a normal batch. To be process oriented and bring all functions of the internal batches together, special versus normal batches must be considered. The goal is to make internal claims processing accountable, measurable, and attainable.

Special Versus Normal Batches

Special batches are claims processing requests that may be Legislative, State, or provider requested. Members of the EDS team may also submit special batches. It is requested that submitters use discretion when submitting special batches with customer service in mind. Normal batches are claims needing processed without major importance and are processed promptly. All claims are processed according to State standards. The preferred method of adjudication is through normal channels.

Normal Batches

As defined earlier, normal batches are claims needing processed within the EDS account organization. The submitter must prepare claims as a provider would submit paper claims to EDS. Normal batches are submitted to the mail preparation area. The batches must be submitted no later than 1:30 p.m. to receive the same day Julian date.

Special Batch Process Requirements

Preparation

Submit a special batch with the *Special Processing Request cover form*. This form is required to process all special batches. An illustration of this form is located in *Appendix A*. The special batch submitter is responsible for requester information. The following fields must be filled in for processing: *Requester*, *Date*, *Department*, *Provider Name*, *Claim Type* (examples of the various claim types are attached to this document), *Provider Error*, *Processing Error*, *County Delay*, *OMPP Referral*, *Reason for Special Batching*, *Special Instructions*, and *Manager's Signature*. The submitter must have the adjustments/resolution's supervisor or claims director's approval for the request. If the request is not approved, an explanation will be documented on the form. The SBC (Special Batch Coordinator) is responsible for documenting the ICN range assigned, date microfilmed, clerk ID, date key entered, clerk ID, error correction, clerk ID, adjudication date, and paid or denied.

Quality Submission

To ensure quality submission of special batches, the SBC verifies that all batch requests are properly prepared for submittal compliance. The submitter is notified if forms are not properly prepared for special batching. If special batches are not properly submitted, the SBC contacts the submitter to arrange a training session. If the submitter has not contacted the SBC for re-batching procedures within three days, the SBC notifies the supervisor to resubmit the batch. The supervisor has two days to resubmit the batch.

Processing Requirements

The SBC reviews the header sheet to process all edits. If the edit or edit description is not provided as a special instruction, then the SBC works the edit as normal.

Receiving Personnel

Special batch requests must be submitted to the Adjustments/Resolutions supervisor for approval. If the Adjustments/Resolutions supervisor is not available, the request is forwarded to the Claims director and then the Resolutions team lead.

Cutoff Time

The cutoff time for special batches is 3:30 p.m. Batches submitted after 3:30 p.m. must be submitted the following day to ensure that

proper tracking protocols are followed. Special batches are submitted with the following day's Julian date.

Special Batch Processing Cycle

Table 3.5 Special Batch Processing Cycle

Departmental Process	Time Allowed
Microfilming and Data Entry	1 Day
Indiana*AIM* Processing	2-Days
Resolutions Adjudication	2-Days
Total	5 Days

Special Batch Complete Notification

Once the special batched claim has been adjudicated, the SBC places a copy of the *Special Processing Request form* in the special batch tray in the Provider Relations area. If another department submits special batches, a copy of the *Special Processing Request form* is placed on the submitter's desk, unless otherwise directed. The entire process requires no more than five business days.

Claims Correction Form Process

A CCF is a claim-specific computer-generated letter sent to the provider indicating that an error was detected precluding claim payment. The CCF identifies the claim in error and lists the errors detected. It also displays the data in the erroneous field and provides a space for the provider to enter corrected data. CCFs cannot be submitted via electronic media. Errors involving missing or invalid data cause the system to generate CCFs. CCFs are picked up by the EDS courier at the post office along with other mail and taken to the EDS Claims Support Unit. The CCFs are sorted by the date the CCF was generated, prepared by single or attachment batches, and given a new ICN through the microfilming process. The new ICN is used to link the CCF to the original ICN. The batches are taken to the Resolutions Unit and processed within five days. The Resolutions Unit logs the CCFs onto a spreadsheet for tracking purposes. The examiners sign out the CCFs and call up the original ICN assigned to the original claim first entered in Indiana*AIM*. The examiner then enters the new ICN in the cross-reference box. This links the CCF to the original ICN. The examiner enters the correct or additional data in the proper fields. The corrections or additional data are applied to the claims and the claims are resubmitted. If the proper corrections are made and no other errors are detected, the claims are approved for payment and assigned an *approved to pay* status. Payment is made

during the next weekly payment cycle. If the corrections applied do not correct the claims, they are denied with the applicable denial codes. If the claims fail another edit or audit, they are suspended for examiner review. If a CCF is generated on a claim and it is not corrected and returned to EDS by the provider within 45 days, these claims are systematically denied.

Edits and Audits

Edits and audits monitor and enforce federal and state laws and regulations. Edit and audit types include *validation*, *relational*, *provider*, *recipient*, *prior authorization*, *history*, *medical policy*, *surveillance*, and *utilization*. See the *Claims Resolutions Manual, Volume 2 of 3* for complete descriptions and guidelines of all edits and audits.

Electronic Claims

There are two basic types of electronic claims: Electronic Claim Submission (ECS) and point of service (POS) interactive.

ECS Claims

ECS claims are submitted to EDS via direct transmission by modem, diskette, magnetic tape, or cartridges. These claims are received in the EDS mailroom by routine mail, priority mail, or courier. They are then taken to the EDS Operations Unit where the data is transferred from the source to Indiana*AIM*.

The claims are sorted by claim type and are pre-edited for format. Incorrectly formatted claims are rejected during this precycle editing and reported back to the submitter (this process is handled in the Systems Unit). Accepted claims are transferred to Indiana*AIM* and Indiana*AIM* assigns an ICN to each claim and subjects the claim to the edits and audits. The claims are then processed the same way as paper claims.

POS Claims

The provider submits POS claims at the time the service is rendered. These claims are transmitted to EDS in an interactive mode. Pharmacy claims submitted in this manner are adjudicated online and a response is transmitted back to the provider indicating whether the claim is approved for payment or not. If the payment of the claim is approved,

then the amount of the payment is also transmitted back to the provider. POS claims are submitted to EDS using EDS provided software that also contains pre-editing functions. This function ensures that the claims are formatted correctly and contain all mandatory elements before they are actually transmitted for processing.

Indiana*AIM* processes these claims in the same manner as ECS claims. POS claims are given processing priority over ECS and paper claims.

Section 4: Windows

Introduction

All windows with the appropriate field definitions and edits are located in the *Teleprocessing User's Guide – Claims I, II, III, IV, V*. Refer to the master library for additional information about Indiana*AIM* windows.

Section 5: Reports

Daily Incoming Claim Disposition Summary (CTL-0140-D)

This report shows the number of claims received by EDS on a daily basis and the disposition of the claims received. Claim disposition is reflected by the location assigned to the claim. EDS controls and tracks the claims received using this report. This allows EDS to ensure that each claim received is accounted for. This report also provides vital information to assist the Resolutions supervisor or lead examiner in determining the daily workflow.

Aged Claims Listing (CTL-0130-D)

This weekly report lists aged claims that have not been resolved. The report is sorted by claim type and lists claims in ICN order. This report displays the current system location of the claim and how long it has been in that location. This report is reviewed weekly and all claims listed on the report are given priority during claim resolution. Each claim is researched to determine the cause of the suspense age and appropriate measures are taken to ensure timely adjudication of the suspended claim. Elapsed days do not include time in a *Hold*, *IFSSA*, *CHSCS*, or *CCF* location. Adjustments are excluded from this report.

The aged claim listing report displays all claims 20 days or older currently suspended in the system. It is used to monitor the weekly aged inventory to ensure that the oldest claims are worked first by the Resolutions examiner.

Aged Active Claim Analysis (CTL-0135-W)

This weekly report lists the number of claims in each age category by claim location. There are six time segments ranging from zero to 91 + days. Adjustments are excluded from this report.

This report is used by EDS and IFSSA to monitor the status of claims in suspense by claim type and to establish claim resolution focus. Claims in suspense for long periods of time receive high processing priority. Large groups of claims within a certain suspense location code receive high priority as well. Trends developed by using this

document are tracked by location codes and the age of suspended claims.

Error Analysis By Suspended Error Code (CLM-0130-W)

This weekly report shows the number of claims per claim type that suspended for each edit. All edits suspending are listed under the error number column with a brief description. For each edit the total number of suspensions for all claims and a total number by each claim type are listed.

This report is used by EDS and IFSSA to monitor weekly edit suspensions for paper, ECS, and POS claims. When high edit counts are identified, research is performed to determine if edits need revision or if providers are experiencing billing problems. If a provider with billing problems is identified, the provider services area may contact the provider to help alleviate or resolve the problems.

Specially Handled and Processed Claims (CLM-0160-W)

This weekly report identifies claims that have been processed for payment through Indiana*AIM* with special considerations requested by IFSSA or EDS. The claims reported are identified with region code *90 – Special Handling*. The report lists each claim ICN that processed, provider number, RID number, from and through dates of services, billed amount, and paid amount.

Edit and Audit Override Analysis (CLM-0155-M)

This monthly report lists the clerk ID who initiated the override, the claim type where the error occurred, the error code, the number of claims with the error code overridden, and the frequency of the overrides.

EDS and IFSSA can identify overridden error codes with this report.

Claim Correction Form By Claim Type (CLM-0120-W)

This report lists each claim type, claim type description, and the total number of CCFs produced for each claim type. A total line indicates the total number of CCFs produced for the week's cycle.

EDS and FSSA can identify the number of CCFs produced for each claim type with this report.

Weekly Claim Adjudication Cycle Time Report (CLM-0165-W)

This report lists claim counts by claim type, and the number of days to reach final status. Final status is reached when claims reaching locations *66 – denied*, *98 – approved for payment*, or *99 – paid for each media type*. Media types include paper, ECS, and POS. This report also lists the percentage of total claim volume by days elapsed and the average age of claims in final status. Data reported occurs over a 30-day period.

EDS and IFSAA can monitor claims processing time with this report.

Daily Claim Activity (CLM-0185-D)

This report provides information on claims, suspense, and adjustments about beginning inventory, new inventory, number processed, and ending inventory.

EDS balances claim and financial cycles with this report. This report also provides the Claims manager with information necessary to manage existing and new inventory.

Claims Processing Assessment System (CPAS) Report

This report selects a statistically valid random sample of different claim types in any status monthly, and performs a quality control check on the claims to ensure accurate processing, including editing, auditing, and pricing.

Section 6: Sample Forms, Letters, and Flowcharts

INDIANA
FAMILY AND SOCIAL SERVICES ADMINISTRATION
CLAIM CORRECTION FORM

999999999
PROVIDER NAME
PO BOX 99999
CITY, ST 99999 9999

Dear Provider:

Your claim for service cannot be processed as submitted because required information is either missing or invalid. The claim in question is identified below.

Following the claim identification is a list of the missing or invalid information. Please review the identified errors, make the necessary entries or corrections on the 'Field Correction' line and return this form to the address provided below.
Thank you.

CLAIM IDENTIFICATION SECTION:

Patient Last Name: XXXXXXXX First Name: XXXXXXX
ICN: 9999999999999 From DOS: MM/DD/YY
Patient Account Number: 999999999 Prescription Number:

CLAIM ERROR CORRECTION SECTION:

LINE NUM	ERROR CODE	ERROR DESCRIPTION	FIELD DESCRIPTION
1	9999	PROCEDURE CODE REQUIRES ATTACHMENT	PROCEDURE CODE

This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of the claim to which this correction will be applied will be from Federal and State funds, and that any falsification of claims, statements or documents, or concealment of material fact may be prosecuted under applicable Federal or State laws.

Mail to:

EDS IndianaAIM

_____

PO Box 7266

Indianapolis, IN 46207-7266

_____

Signature of Provider
Date
or Representative

Please make the necessary corrections and mail this form by MM/DD/CCYY

Figure 6.1 – Sample of Claim Correction Form

Adjustments/Resolutions Department

SPECIAL BATCH REQUEST FORM

Requester: _____ Date: _____

Department: _____ Provider name: _____

Claim type (circle one) A B C D H I L M O P Q

Request type (check appropriate box)

☐ Provider Error ☐ Processing Error ☐ County/State Delay ☐ OMPP Referral

Reason for Special Processing:

_____

_____

_____

_____

_____

Special Instruction/Request:

_____

_____

_____

_____

_____

Manager Signature: _____

Claims Department Use Only

Approved for: ☐ Special Batching ☐ Normal Processing ☐ Priority ☐ Disapproved

If disapproved indicate reason below:

_____

_____

_____

Claims Manager Signature: _____

If Approved: ICN Range Assigned _____ to _____

Date Microfilmed: _____ Clerk ID _____

Date Key Entered: _____ Clerk ID _____

Error Correction: _____ Clerk ID _____

Error Correction: _____ Clerk ID _____

Adjudication Date: _____ ☐ Paid ☐ Denied

Figure 6.2 – Special Batch Request Form

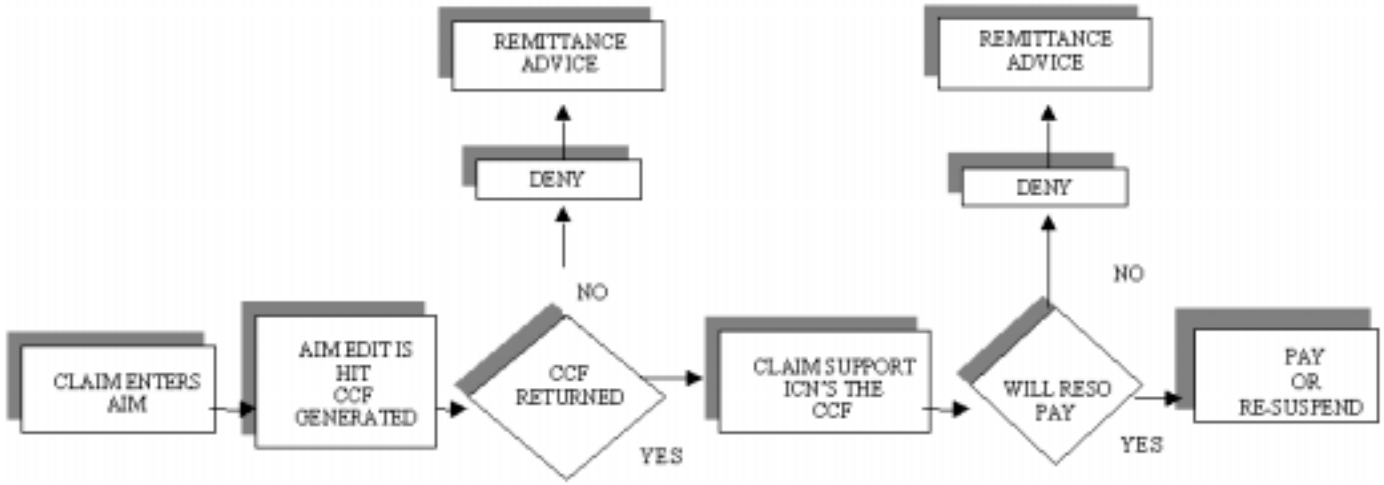

Figure 6.3 – Claim Correction Form Flowchart

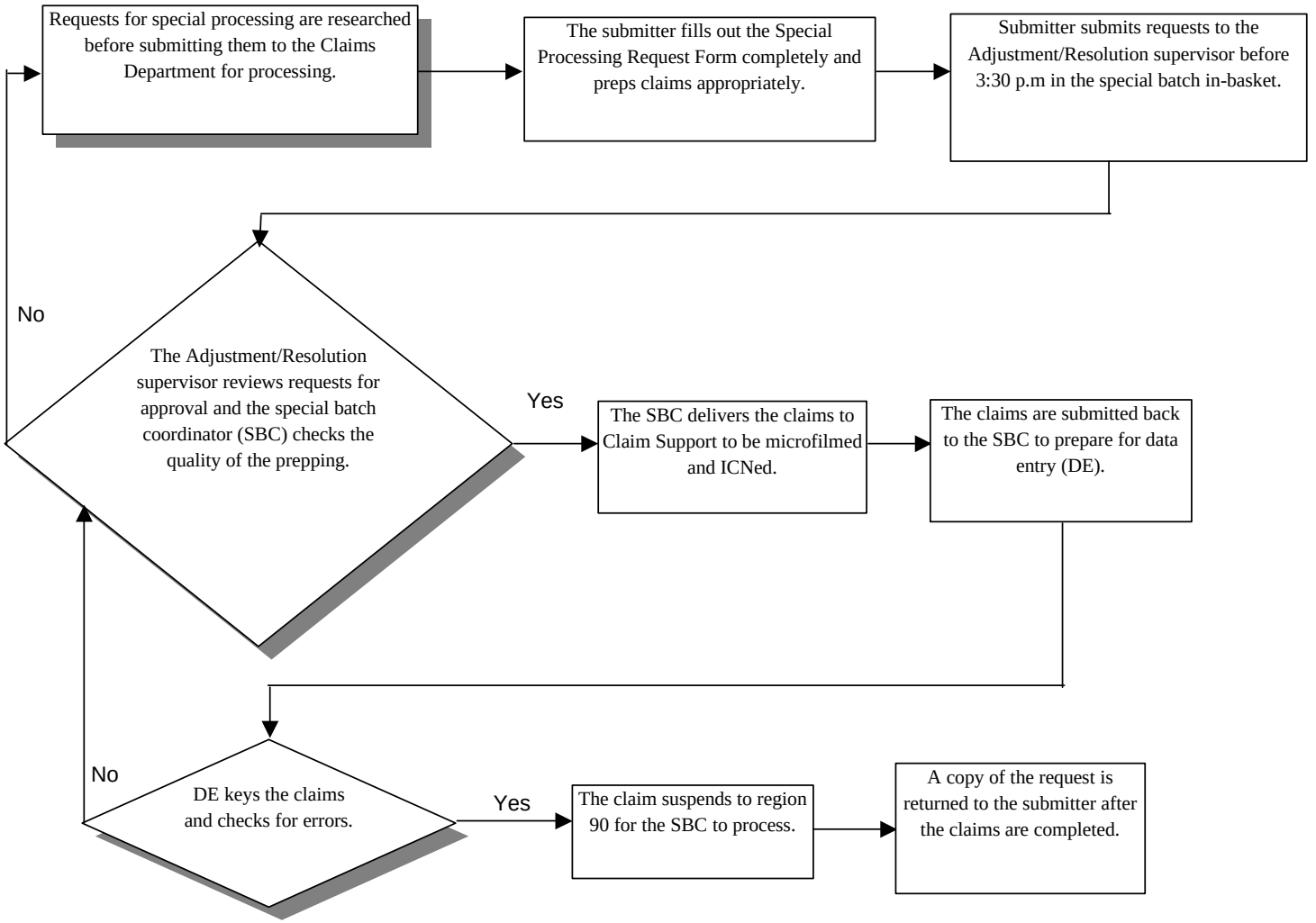

Figure 6.4 – Special Batches Flowchart

RESOLUTION FLOWCHART

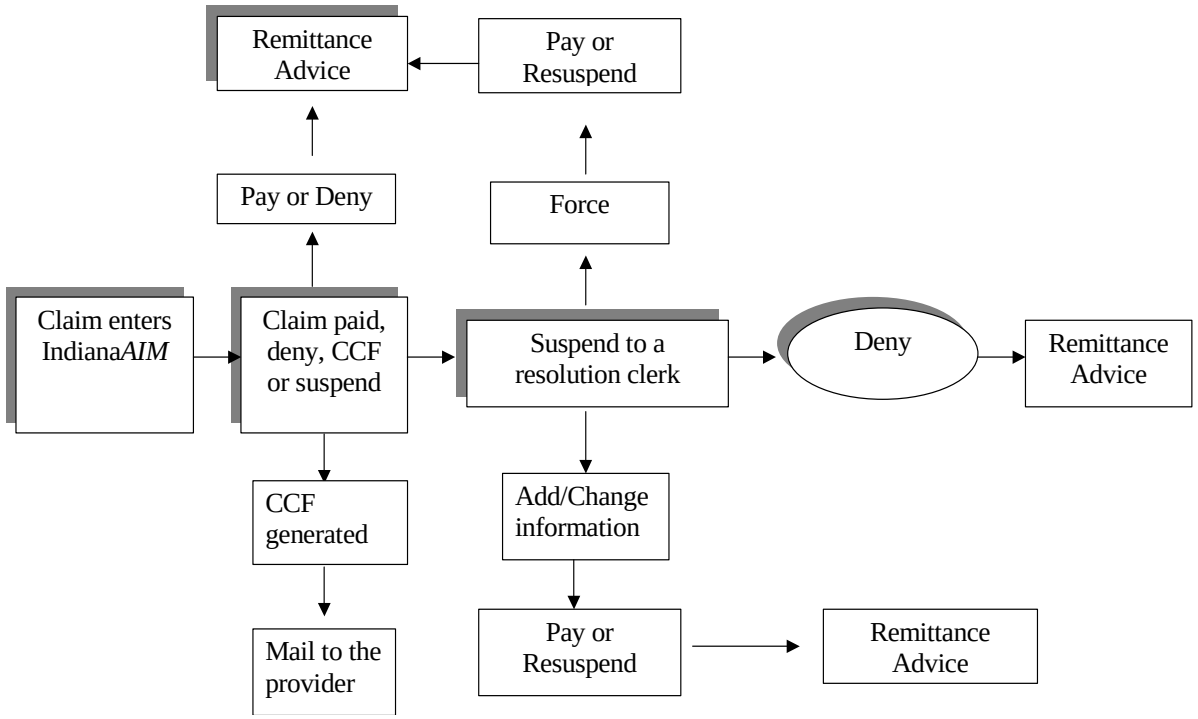

Figure 6.5 – Resolution Flowchart

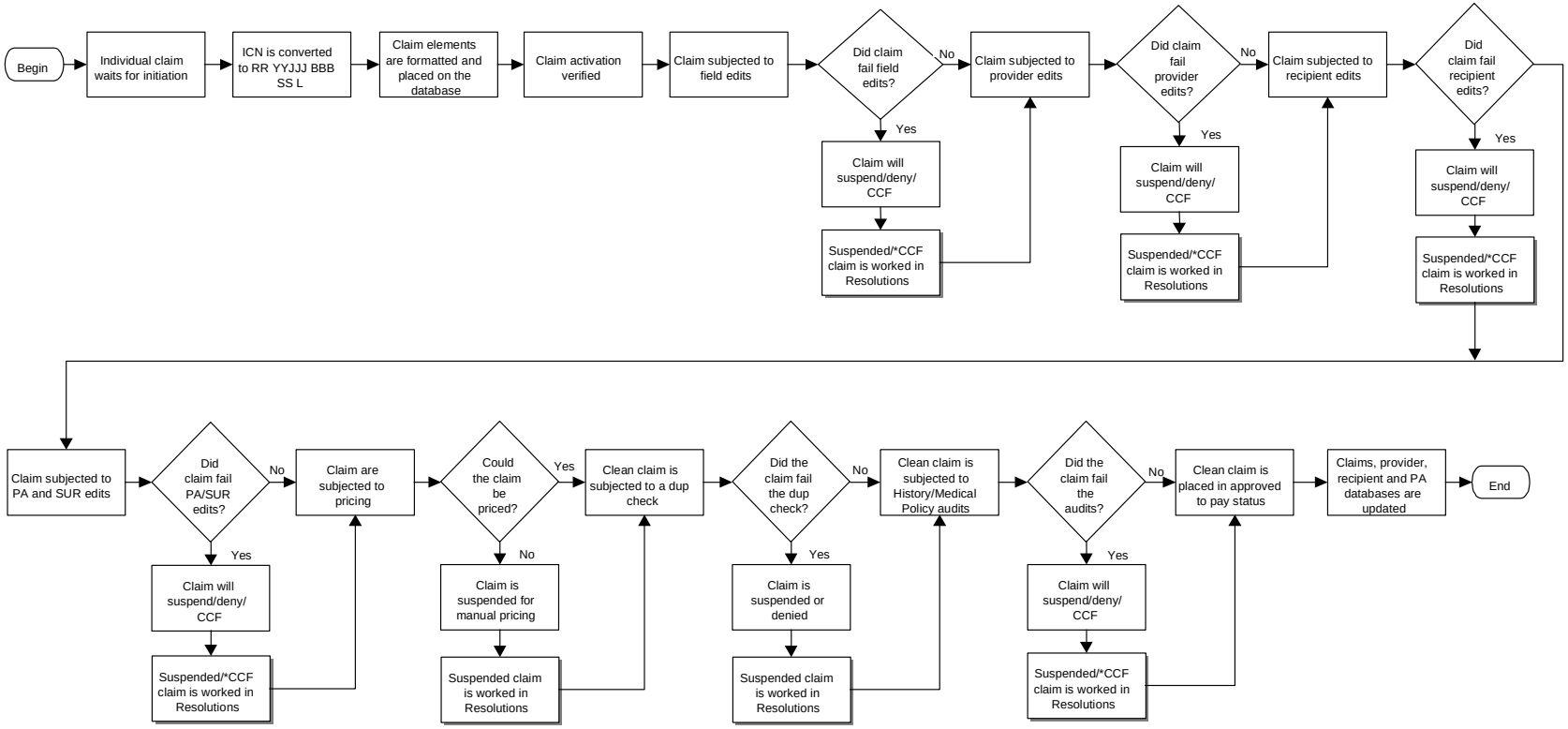

Figure 6.6 - Claims Processing Work Flow Procedures

Section 7: Performance Standards

Indiana*AIM* Performance Standards

Table 7.1 – Performance Standard for Contract Requirement 2.5.1.5.2.d

Department/Unit:	Claims Resolutions Unit
Performance Standard:	Manually and systematically review and resolve any claims that suspend for any of the edits or audits as determined by the State.
RFP Requirement No.:	2.5.1.5.2.d
Quality Process:	
Frequency:	Daily
Personnel:	The Resolutions examiner
Procedure:	Examiners process data corrections on a daily basis. Suspended claims are adjudicated according to written guidelines on the edit or audit resolution page.
Monitoring:	Review a percentage of processed work to verify that examiners are adjudicating the edit or audit in accordance with edit or audit criteria.

Table 7.2 – Performance Standard for Contract Requirement 2.5.1.8.2.g

Department/Unit:	Claims Resolutions Unit
Performance Standard:	Maintain sufficient staff to manually price certain claims according to State-specified criteria.
RFP Requirement No.:	2.5.1.8.2.g
Quality Process:	
Frequency:	As needed
Personnel:	Claims manager, Resolutions supervisor, and the lead examiner
Procedure:	Review and monitor incoming mail, suspense error rate, and production on the current staff.
Monitoring:	Includes, but is not limited to, claim report *CLM-0140-D*

Table 7.3 – Performance Standard for Contract Requirement 2.5.1.8.2.h

Department/Unit:	Claims Resolutions Unit
Performance Standard:	Price all claims in accordance with Indiana medical assistance program policy, benefits, and limitations as defined by the State.
RFP Requirement No.:	2.5.1.8.2.h
Quality Process:	
Frequency:	Daily
Personnel:	Lead examiners, examiners, and unit supervisor
Procedure:	Price the claim in accordance with manual pricing guidelines when a claim suspends for manual pricing.
Monitoring:	Review a percentage of processed claims for each examiner on a daily, weekly, or monthly basis depending on the examiner's experience level.

Table 7.4 – Performance Standard for Contract Requirement 2.5.1.8.2.i

Department/Unit:	Claims Resolutions Unit
Performance Standard:	Process Medicare coinsurance and deductible charges from providers on hardcopy and electronic media.
RFP Requirement No.:	2.5.1.8.2.i
Quality Process:	
Frequency:	Daily
Personnel:	Resolutions examiners
Procedure:	Process suspended claims on a daily basis, identify and correctly adjudicate the claim with the proper attachments.
Monitoring:	Review a random sample of processed claims for each examiner.

Table 7.5 – Performance Standard for Contract Requirement 2.5.1.8.2.k

Department/Unit:	Claims Resolutions Unit
Performance Standard:	Monitor the use of override codes during the claims resolution process to identify potential abuse, based on State-defined guidelines.
RFP Requirement No.:	2.5.1.8.2.k
Quality Process:	
Frequency:	Monthly
Personnel:	Supervisor and lead examiners.
Procedure:	Identify and monitor each overridden error code and the frequency of the overrides.
Monitoring:	Claim report *CLM-0150-M* is used by the Claims manager, unit supervisor, or lead examiners.

Table 7.6 – Performance Standard for Contract Requirement 2.5.1.8.3.a

Department/Unit:	Claims Resolutions Unit
Performance Standard:	Perform at least three edit processing cycles weekly
RFP Requirement No.:	2.5.1.8.3.a
Quality Process:	
Frequency:	Weekly
Personnel:	Systems Department
Procedure:	System is programmed to execute claim edit cycles three times per week.
Monitoring:	Routine monitoring is not performed. Criteria to meet this requirement are automated in Indiana*AIM*.

Table 7.7 – Performance Standard for Contract Requirement 2.5.1.8.3.b

Department/Unit:	Claims Resolutions Unit
Performance Standard:	Perform at least two audit processing cycles weekly
RFP Requirement No.:	2.5.1.8.3.b
Quality Process:	
Frequency:	Weekly
Personnel:	Systems Department
Procedure:	System is programmed to execute claim audit cycles two times per week.
Monitoring:	Routine monitoring is not performed. Criteria to meet this requirement are automated in Indiana*AIM*.

Table 7.8 – Performance Standard for Contract Requirement 2.5.1.8.3.c

Department/Unit:	Claims Resolutions Unit
Performance Standard:	Perform at least two pricing cycles weekly.
RFP Requirement No.:	2.5.1.8.3.c
Quality Process: **Frequency:** **Personnel:** **Procedure:**	 Weekly Systems Department System is programmed to execute claim audit cycles two times per week.
Monitoring:	Routine monitoring is not performed. Criteria to meet this requirement are automated in Indiana*AIM*.

Table 7.9 – Performance Standard for Contract Requirement 2.5.1.8.3.d

Department/Unit:	Claims Resolutions Unit
Performance Standard:	Correctly adjudicate all suspended claims, except those suspended for medical review, within 30 days of receipt, or as specified in the most current Federal SPR standards, whichever is less.
RFP Requirement No.:	2.5.1.8.3.d
Quality Process: **Frequency:** **Personnel:** **Procedure:**	 Monthly Resolutions examiners Process each suspended claim in accordance with established guidelines within thirty days of receipt.
Monitoring:	Claim control reports *CTL-0130-W* and *CTL-0135-W* are used by the Claims manager, unit supervisor, or lead examiner.

Section 8: Quality Management

Indiana*AIM* Quality Management

Table 8.1 – Performance Standard for Accuracy Rate

Department/Unit:	Claims Resolutions Unit
Performance Standard:	Acceptable accuracy rate for an examiner in the Claims Resolutions Unit is 97 percent. An error rate of three percent is deemed acceptable although the examiners are encouraged to achieve a lower error rate.
Quality Process:	
Frequency:	Quality checks on the examiners are based on the examiner's experience and expertise. The work performed by newly hired examiners is evaluated on a daily basis. More experienced examiners are evaluated weekly or monthly, depending on the results of previous quality checks. Examiners undergoing training on new functions or claim types are evaluated more frequently than examiners who are performing functions they are familiar with.
Personnel:	Supervisor and lead examiners. An experienced examiner may be asked to perform quality checks on new examiners.
Procedure:	Supervisor or lead examiner enters the type of claims to be selected, the examiner's user ID, percentage, and maximum number on the Claims QA Review Criteria window. The supervisor also indicates if the claim is to be released into the cycle if not reviewed by cycle time. With this capability, quality assurance controls can be practiced as often as necessary on any of the examiners in the unit on any given day. After the claims have been selected, the claims processing system automatically suspends further processing of these claims and stores them in a directory that is accessible to the unit supervisor via the Data Correction Claim Assignment and Review window. The claims are then checked for accuracy and released. If errors are discovered, the claims are held and shown to the examiners. Corrections are then performed and the claims are released or resubmitted for further processing.
Monitoring:	Unit supervisor or lead keeps a log for each examiner, to track accuracy as well as, the type of error found. Data is analyzed to determine if additional training is needed.

Glossary

1115(a)	Section of the Social Security Act that allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, system-wide changes are possible under this provision. Waivers must be approved by HCFA. See also *Health Care Financing Administration, PACE, Waiver*.
11971	State form 11971; see *8A*.
1261A	Division of Family and Children State Form 1261A, *Certification - Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*.
1500	This is a claim form used by participating Medicaid providers to bill medical and medically related services.
1902(a)(1)	Section of the Social Security Act that requires state Medicaid programs be in effect "in all political subdivisions of the state". See also *Statewideness.*
1902(a)(10)	Section of the Social Security Act that requires state Medicaid programs provide services to people that are comparable in amount, duration and scope. See also *Comparability; Sections 1915(a), (b), and (c); Waiver*.
1902(a)(23)	Section of the Social Security Act that requires state Medicaid programs ensure clients have the freedom to choose any qualified provider to deliver a covered service. See also *Freedom of Choice, Section 1915(b), Waiver.*
1902(r)(2)	Section of the Social Security Act that allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income (SSI) eligibility for determining Medicaid eligibility.
1903(m)	Section of the Social Security Act that allows state Medicaid programs to develop risk contracts with health maintenance organizations or comparable entities. See also *Risk Contracts*.
1915(b)	Section of the Social Security Act that allows states to waive Freedom of Choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager. Waivers must be approved by CMS.
1915(c)	Section of the Social Security Act that allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an ICF-MR, nursing facility or Institution for Mental Disease, or inpatient hospital. Waivers must be approved by CMS. See also *CLASS, HCS, MDCP, CMS, NF, Waiver.*
1915(c)(7)(b)	Section of the Social Security Act that allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by CMS. See also *CMS, HCS-O, Waiver*.

1929	Section of the Social Security Act that allows states to provide a broad range of home and community care to functionally disabled individuals as an optional state plan benefit. The option can serve only people over 65. In Indiana, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also *Home and Community Care*.
450A	Social Evaluation for Long Term Care Admission.
450B	Certification by Physician for Long Term Care Services.
590 Program	A program for institutionalized persons under the jurisdiction of the Department of Corrections, Division of Mental Health, and Department of Health.
7748	State Form 7748, Medicaid Financial Report.
8A	DPW Form 8A State Form 11971, *Notice to Provider of Recipient Deductible.* Used to relay recipient spenddown information to providers.
AAA	Area Agency on Aging. This agency is a significant element in Home and Community-Based Services Waiver Programs.
AAP	American Academy of Pediatrics.
ABA	American Banking Association.
access	Term used to describe the action of entering and utilizing a computer application.
accommodation charge	A charge used only in institutional claims for bed, board, and nursing care.
accretion	An addition to a file or list. For example: the monthly additions to the Medicare Buy-In List.
ACSW	Academy of Certified Social Worker.
ADA	American Dental Association.
ADC	Adult Day Care.
adjudicate (claim, credit, adjustment)	To process a claim to pay or deny.
adjustment	(1) A transaction that adjusts and reprocesses a previously processed claim; (2) the contractor adjusts a provider's account by debiting underpayments or crediting overpayments on claims.
adjustment recoupments	Recoupments set up by the adjustments staff on recoup and reprocess transactions. A record of these recoupments is maintained by the Cash Control System until zero balanced.

Advance Planning Document (APD)	A planning guide the federal government requires when a state is requesting 90 percent funding for the design, development, and implementation of an MMIS.
AFDC	Aid to Families with Dependent Children (AFDC) is replaced with Temporary Assistance for Needy Families (TANF).
AG	Attorney General.
Aged and Medicare-Related Coverage Group	Needy individuals who have been designated by Department of Human Services (DHS) as medical assistance recipients, who are 65 years old or older, or recipients under any other category who are entitled to benefits under Medicare.
aid category	A designation within the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Aid to Families with Dependent Children (AFDC)	Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act.
Aid to the Blind (AB)	A classification or category of recipients eligible for benefits under the Medicaid Program.
AIM	Advanced Information Management.
allowed amount	Either the amount billed by a provider for a medical service, the Department's established fee, or the reasonable charge, whichever is the lesser figure.
alpha	A field of only alphabetical letters.
alphanumeric	A field of numbers and letters.
ambulance service supplier	A person, firm or institution approved for and participating in Medicare as an air, ground, or host ambulance service supplier or provider.
amount, duration, and scope	How an IHCP benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.
ancillary charge	A charge, used only in institutional claims, for any item except accommodation fees. Examples include drug, laboratory and x-ray charges.
APS	Adult Protective Services.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
Area Agency on Aging	Also known as AAA. This agency is a significant element in Home and Community-Based Services Waiver Programs.

Area Prevailing Charge	Under Medicare Part B, the charge level that on the basis of statistical data would cover the customary charges made for similar services in the same locality.
ASC	Ambulatory Surgery Center.
AT	Action Team.
auto assignment	Indiana*AIM* process that automatically assigns a managed care recipient to a managed care provider if the recipient does not select a provider within a specified time frame.
Automated Voice Response (AVR)	Computerized voice response system that helps providers obtain pertinent information concerning recipient eligibility, benefit limitation, check information, and prior authorization (PA) for those participating in the IHCP.
Average Wholesale Price; used in reference to drug pricing.	Indiana*AIM* process that automatically assigns a managed care recipient to a managed care provider if the recipient does not select a provider within a specified time frame.
AVR	Automated voice-response system used by providers to obtain pertinent information concerning recipient eligibility, benefit limitation, check information, and PA for IHCP participants.
AWP	Average wholesale price used for drug pricing.
banner page	Brief messages sent to providers with the weekly remittance advices (RAs).
behavorial health care	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
BENDEX	Beneficiary Data Exchange. A file containing data from HCFA regarding persons receiving Medicaid benefits from the Social Security Administration.
Beneficiary	One who benefits from program such as the IHCP. Most commonly used to refer to people enrolled in the Medicare program.
benefit	A schedule of health care service coverage that an eligible participant in the IHCP receives for the treatment of illness, injury, or other conditions allowed by the State.
benefit level	Limit or degree of services a person is entitled to receive based on his or her contract with a health plan or insurer.
bidder	Any corporation, company, organization, or individual that responds to a Request for Proposal (RFP).
bill	Refers to a bill for medical services, the submitted claim document, or the electronic media claims (EMC) record. A bill may request payment for one or more performed services.

billed amount	The amount of money requested for payment by a provider for a particular service rendered.
billing provider	The party responsible for submitting to the department the bills for services rendered to an IHCP recipient.
billing service	An entity under contract with a provider who prepares billings on behalf of the provider for submission to payers.
block	Specific area on a claim or worksheet containing claim information.
Blue Book	The *American Druggist Blue Book*, used as a reference in pricing drug products.
Boren Amendment	An amendment to *OBRA 80 (P.O. 96-499)*, which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities (NF) and intermediate care facility for the mentally retarded (ICF/MR) under the IHCP. The amendment substituted language that required states to develop payment rates that were "reasonable and adequate" to meet the costs of "efficiently and economically operated" providers. Boren was intended to give states new flexibility but it has increased successful lawsuits by providers and thus has contributed to the rising cost of Medicaid-funded institutional care.
budgeted amount	The planned expenditures for a given time period.
bulletins	Informational directives sent to providers of Medicaid services containing information on regulations, billing procedures, benefits, processing, or changes in existing benefits/procedures.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP recipients, enrolling them in Medicare Part A or Part B or both programs.
C&T	Certification and Transmittal, a document from the Indiana State Department of Health (ISDH) that certifies institutional providers.
C519	Authorization for Recipient Liability Deviation, generated by the Medicaid recipient's county caseworker. Applies only to nursing residents.
cap	A finite limit on the number of certain services for which the department will pay for a given recipient per calendar year.
capitation	A prospective payment method that pays the provider of service a uniform amount for each person served usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.
carrier	An organization processing Medicare claims on behalf of the federal government.
carve out	A decision to purchase separately a service that is typically a part of an indemnity (a HMO plan). (For example, the behavioral health benefit might be carved out to a specialized vendor to supply these services as stand-alone.)

case management	A process whereby covered persons with specific health care needs are identified and a plan which efficiently uses health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.
case manager	An experienced professional (for example, nurse, doctor or social worker) who works with clients, providers, and insurers to coordinate all necessary services to provide the client with a plan of medically necessary and appropriate health care.
Cash Control Number (CCN)	Financial control number assigned to uniquely identify all refunds or repayments prior to their setup within the cash control system. The batch range within the CCN identifies the type of refund or repayment.
cash control system	Process whereby the case unit creates and maintains the records for accounts receivable, recoupments, and payouts.
categorically needy	All individuals receiving financial assistance under the State's approved plan under Titles I, IV-A, X, XIV, and XVI of the Social Security Act or who are in need under the State's standards for financial eligibility in such plan.
category code	A designation indicating the type of benefits for which an IHCP recipient is eligible.
category of service	A designation of the nature of the service rendered (for example, hospital outpatient, pharmacy, physician).
CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider who submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CDFC	County Division of Family and Children.
CEO	Chief Executive Officer.
certification	A review of CMS of an operational MMIS in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system; also, the ensuing certification resulting from a favorable review.
certification code	A code PCCM PMPs use to authorize PCCM recipients to seek services from specialty providers.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CHAMPUS	Civilian Health and Medical Plan for the Uniformed Services; health-care plan for the uniformed services outside the military health-care system, now know as TRICARE.
charge center	A provider accounting unit within an institution used to accumulate specific cost data related to medical and health services rendered (for example, laboratory tests, emergency room service, and so forth.).

Children's Special Health Care Services (CSHCS)	State program that provides assistance for children with chronic health problems who are not necessarily eligible for Medicaid.
CI	Continual improvement.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: HCFA-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
Claim Correction Form (CCF)	Automatically generated for certain claim errors and sent to providers with the weekly RA. Allows providers the opportunity to correct specified errors detected on the claim during the processing cycle.
claim transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: (1) Claims (2) Credits (3) Adjustments.
claim type	Three-digit numeric code that refers to the different billing forms used by the program.
claims history file	Computer file of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
claims processing agency	Agency that performs the claims processing function for Medicaid claims. The agency may be a department of the single state agency responsible for Title XIX or a contractor of the agency, such as a fiscal agent.
clean claim	Claim that can be processed without obtaining additional information from the provider or from a third party.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
client	A person enrolled in the IHCP and thus eligible to receive services funded through the IHCP. See also *Recipient*.
CMHC	Community Mental Health Center.
CMS	Centers for Medicare & Medicaid Services. Effective August 2001, this is the new name of the federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs. It was formerly known as the Health Care Financing Administration (HCFA).
co-insurance	The portion of Medicare-determined allowed charge that a Medicare recipient is required to pay for a covered medical service after his/her deductible has been met. The co-insurance or a percentage amount is paid by Medicaid if the recipient is eligible for Medicaid. See also *Cost Sharing*.

Commerce Clearing House Guide	A publication containing Medicaid and Medicare regulations.
Community Living Assistance and Support Services (CLASS)	A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to people with development disabilities other than mental retardation as an alternative to ICF MR VIII institutional care. Administered by Department of Human Services (DHS). See also *ICF MR, 1915(c), Waiver*.
Computer-Output Microfilm (COM)	The product of a device that converts computer data directly to formatted microfilm images bypassing the normal print of output on paper.
concurrent care	Multiple services rendered to the same patient during the same time period.
consent to sterilization	Form used by IHCP recipients certifying that they give "informed consent" for sterilization to be performed (it must be signed at least 30 days prior to sterilization).
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
contractor, contractors, or the contractor	Refers to all successful bidders for the services defined in any contract.
conversion factor	Number that when multiplied by a particular procedure code's relative value units would yield a substitute prevailing charge that could be used when an actual prevailing charge does not exist.
co-payment or co-pay	A cost-sharing arrangement that requires a covered person to pay a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. See also *Cost Sharing*.
core contractor	Vendor that successfully bids *on Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services.*
COS	Category of Service.
cost settlement	Process by which claims payments to institutional providers are adjusted yearly to reflect actual costs incurred.

cost sharing	The generic term that includes co-payments, coinsurance, and deductibles. Co-payments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (for example, 20 percent) that an insured person must pay out-of-pocket. Deductibles are specified caps on out-of-pocket spending that an individual or a family must incur before insurance begins to make payments.
county office	County offices of the Division of Family and Children. Offices responsible for determining eligibility for IHCP using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP recipients.
CP	Clinical psychologist.
CPAS	Claims Processing Assessment System. An automated claims analysis tool used by the State for contractor quality control reviews.
CPS	Child Protective Services.
CPT Codes (Current Procedural Terminology)	Unique coding structure scheme of all medical procedures approved and published by the American Medical Association.
CPU	Central processing unit.
CQM	Continuous quality management.
credit	A claim transaction that has the effect of reversing a previously processed claim transaction.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
Crippled Children's Program	Title V of the Social Security Act allowing states to locate and provide health services to crippled children or children suffering from conditions leading to crippling. Former term for CSHCS.
CRNA	Certified registered nurse anesthetist.
crossover claim	A claim for services, rendered to a patient eligible for benefits under both Medicaid and Medicare Programs, Titles XVIII and XIX, potentially liable for payment of qualified medical services. (Medicare benefits must be processed prior to Medicaid benefits).
CRT Terminal (Cathode-Ray Tube Terminal)	A type of input/output device that may be programmed for file access capabilities, data entry capabilities or both.

CSHCS	Children's Special Health Care Services. A state-funded program providing assistance to children with chronic health problems. CSHCS recipients do not have to be IHCP-eligible. If they are also eligible for IHCP, children can be enrolled in both programs.
CSR	Customer Service Request.
CSW	Clinical social worker.
customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP, including state staff, members, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).
data element	A specific unit of information having a unique meaning.
DD	Developmentally disabled or developmental disabilities.
DDARS	Division of Disability, Aging, and Rehabilitative Services.
deductible	Fixed amount that a Medicare recipient must pay for medical services before Medicare coverage begins. The deductible must be paid annually before Part B medical coverage begins; and it must be paid for each benefit period before Part A coverage begins.
DESI	Drug determined to be less than effective (LTE); not covered by the IHCP.
designee	Duly authorized representative of a person holding a superior position.
detail	Information on a claim that denotes a specific procedure or category of certain services and the total charge billed for the procedure(s) involved. Also used to describe lines within a screen segment; for example, those listed to describe periods of eligibility.
development disability	Mental retardation of a related condition. A severe, chronic disability manifested during the developmental period that results in impaired intellectual functioning or deficiencies in essential skills. See also *Mental Retardation, Related Condition.*
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through the CMS.
DHS	Department of Health Services.
diagnosis	The classification of a disease or condition. (1) The art of distinguishing one disease from another. (2) Determination of the nature of a cause of a disease. (3) A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem. (4) A code for the above. See also *ICD-9-CM, DRG*.
digit	Any symbol expresses an idea or information, such as letters, numbers, and punctuation.
direct price	Price the pharmacist pays for a drug purchased from a drug manufacturer.

disallow	To determine that a billed service(s) is not covered by the IHCP and will not be paid.
disposition	Application of a cash refund to a previously finalized claim. Also used in processing claims to identify claim finalization—payment or denial.
DME	Durable medical equipment. Examples include wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DMH	Division of Mental Health.
DOS	Date of service; the specific day services were rendered.
down	Term used to describe the inactivity of the computer due to power shortages or equipment problems. Entries on a terminal are not accepted during down time.
DPOC	Data Processing Oversight Commission. Indiana agency overseeing agency compliance with all State data processing statutes, policies, and procedures.
DPOC	Data Processing Oversight Commission. Indiana agency providing oversight and review of all State data processing statutes, policies, and procedures.
DPW	Department of Public Welfare, the previous name of the Office of Medicaid Policy and Planning.
DPW Form 8A	See *8A*.
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
drug code	Code established to identify a particular drug covered by the State Medicaid Program.
Drug Efficacy Study Implementation (DESI)	Listed drugs considered to be less than effective by the U.S. Food and Drug Administration. See also *Notice of Opportunity for Hearing (NOOH)*.
drug formulary	List of drugs covered by a State Medicaid Program, which includes the drug code, description, strength and manufacturer.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSM	Diagnostic and Statistical Manual of Mental Disorders; a revision series is usually associated with the reference, as well.
DSS	Decision Support System. A data extraction tool used to evaluate Medicaid data, trends, and so forth, for the purpose of making programmatic decisions.
dual eligible	A person enrolled in Medicare and Medicaid.
duplicate claim	A claim that is either totally or partially a duplicate of services previously paid.

DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and PCs for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECF	Extended care facility; primarily seen as LTC, long-term care; also seen as NH or NF.
ECM	Electronic claims management. Claims submitted in electronic format rather than paper. See **ECC, EMC**.
ECS	Electronic claims submittal. Claims submitted in electronic format rather than paper. See **ECC, EMC**.
EDI	Electronic data interchange.
EDP	Electronic data processing.
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
eligibility file	File containing individual records for all persons who are eligible or have been eligible for the IHCP.
eligible providers	Person, organization, or institution approved by the Single State Agency as eligible for participation in the IHCP.
eligible recipient	Person certified by the State as eligible for medical assistance in accordance with the State Plan(s) under Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, or State law.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See **ECC, ECS.**
EMS	Emergency medical service.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's RA.
EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to recipients. The EOMB details the payment or denial of claims submitted by providers for services provided to recipients.
EOP	Explanation of payment. Describes the reimbursement activity on the provider's RA.

EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for Medicaid-eligible recipients under 21 years old, offering free preventive health care services, such as screenings, well-child visits, and immunizations. If medical problems are discovered, the recipient is referred for further treatment.
error code	Code connected to a claim transaction indicating the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.
errors	Claims that are suspended prior to adjudication. Several classifications of errors could exist; for example claims with data discrepancies or claims held up for investigation of possible third party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design. See also *Rejected Claim*.
ESRD	End-stage renal disease.
EST	Eastern Standard Time, which is also Indianapolis local time.
EVS	Eligibility Verification System. System used by providers to verify recipient eligibility using a point-of-sale device, online PC access, or an AVR system.
exclusions	Illnesses, injuries, or other conditions for which there are no benefits.
Exclusive Provider Organization (EPO)	Arrangement between a provider network and a health insurance carrier or self-insured employer that requires the beneficiary to use only designated providers or sacrifice reimbursement altogether. See also *Preferred Provider Organization.*
Explanation of benefits (EOB)	An explanation of claim denial or reduced payment included on the provider's RA.
Family Planning Service	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.
FAMIS	Family Assistance Management Information System.
Fee-For-Service Reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide. See also *Indemnity Insurance*.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.

field audit	A provider's facilities, procedures, records and books are reviewed for conformance to IHCP standards. A field audit may be conducted regularly, routinely, or on a special basis to investigate suspected misutilization.
FIPS	Federal information processing standards.
fiscal month	Monthly time interval in a fiscal year.
fiscal year	Twelve-month period between settlements of financial accounts.
fiscal year – federal	October 1 - September 30.
fiscal year – Indiana	July 1 - June 30.
flat rate	Reimbursement methodology in which all providers delivering the same service are paid at the same rate. Also known as a Uniform Rate.
FMAP	Federal Medical Assistance Percentage. The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
Form 1261A	Division of Family and Children State Form 1261A, *Certification - Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*.
FPL	Federal poverty level. Income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.
FQHC	Federally Qualified Health Center. A center receiving a grant under the Public Health Services Act or entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.
freedom of choice	A State must ensure that IHCP beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.
front end	First process of claim cycle designed to create claim records, perform edits, and produce inventory reports.
front-end process	All claims system activity that occurs before auditing.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the Indiana Medicaid program.

FUL	Federal upper limit, the pricing structure associated with maximum allowable cost (MAC) pricing.
generic drug	A chemically equivalent copy designed from a brand name whose patent has expired and is typically less expensive.
Group Model Health Maintenance Organization	A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
group practice	A medical practice in which several physicians render and bill for services under a single billing provider number.
hard copy claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as “paper” and “manual”.
HBP	Hospital-Based Physician. A physician who performs services in a hospital setting and has a financial arrangement to receive income from that hospital for the services performed.
HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged recipients to allow them to live in the community and avoid being placed in an institution.
HCE	Health Care Excel.
HCFA	Health Care Financing Administration. This is the previous name of the federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs. Effective August 2001, it is called the Centers for Medicare & Medicaid Services.
HCFA-1500	HCFA-approved standardized claim form used to bill professional services.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	HCFA Common Procedure Coding System. A uniform health care procedural coding system approved for use by HCFA. HCPCS includes all subsequent editions and revisions.
header	Identification and summary information at the head (top) of a claim form or report.
HealthWatch	Indiana’s preventive care program for Medicaid recipients under 21 years of age. Also known as EPSDT.
HEDIS	Health Plan Employer Data and Information Set. A core set of performance measures developed for employers to use in assessing health plans.
help	An online computer function designed to assist users when encountering difficulties entering a screen.

HHA	Home Health Agency. An agency or organization approved as a home health agency under Medicare and designated by ISDH as a Title XIX home health agency.
HHPD	Hoosier Healthwise for Persons with Disabilities and Chronic Diseases, formerly referred to as MCPD. HHPD is one of three delivery systems in the Hoosier Healthwise managed care program. In HHPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
HHS	Health and Human Services. U.S. Department of Health and Human Services. Umbrella agency for the Office of Family Assistance, the CMS, the Office of Refugee Resettlement (ORR), and other federal agencies serving health and human service needs.
HIC #	Health Insurance Carrier Number. Identification number for those patients with Medicare coverage. The HIC# is usually the patient's Social Security number and an alphabetic suffix that denotes different types of benefits.
HIO	Health insuring organization.
HIPP	Health insurance premium payments.
HMO	Health maintenance organization. Organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also *Sections 1903(m) and 1915 (b), PHP, PPO, Primary Care Case Management.*
HMS	Health Management Services.
Home and Community Care for the Functionally Disabled	An optional state plan benefit that allows states to provide HCBS to functionally disabled individuals (In Indiana, this optional benefit is used by ISDH to provide personal care services to people who have income in excess of SSI limitations but who would be financially qualified in an institution.) Also known as the "Frail Elderly" provision, although Indiana can serve people of any age under this provision. See also *Section 1919, Primary Home Care.*
Home and Community-Based Services-Omnibus Budget Reconciliation Act (HCS-OBRA)	A waiver of the Medicaid state plan granted under Section *1915(c)(7)(b)* of the Social Security Act that allows Indiana to provide community-based services to certain people with developmental disabilities placed in nursing facilities but requiring specialized service according to the PASARR process. See also *Section 1915(c)(7)(b), PASARR, Waiver.*
Home Health Care Services	Visits ordered by a physician authorized by DHS and provided to homebound recipients by licensed registered and practical nurses and nurses aids from authorized home health care agencies. These services include medical supplies, appliances, and DME suitable for use in the home.

Hoosier Healthwise	IHCP managed-care program. Hoosier Healthwise has three components including Primary Care Case Management (PCCM), Risk-Based Managed Care (RBMC), and Managed Care for Persons with Disabilities (MCPD).
HPB	Health Professions Bureau.
HRI	Health-related items.
IAC	Indiana Administrative Code. State government agency administrative procedures.
IC	Indiana code.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of the Division of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF	Intermediate care facility. Institution providing health-related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing home, but who, because of their physical or mental condition, require services beyond the level of room and board.
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for Medicaid-eligible, mentally retarded individuals.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
ICU	Intensive care unit.
IDDARS	Indiana Division of Disability, Aging, and Rehabilitative Services.
IDEA	Individuals with Disabilities Education Act.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IEP	Individual Education Program (in relation to the First Steps Early Intervention System).
IFSP	Individual Family Service Plan (in relation to the First Steps Early Intervention System).
IFSSA	Indiana Family and Social Services Administration.
IMCA	Indiana Motor Carrier Authority.
IMD	Institutions for mental disease.

IMF	Indiana Medical Foundation. Non-profit organization contracted by the DHS for the daily review and correction of abstracts submitted by all IHCP hospitals in Indiana.
IMFCU	Indiana Medicaid Fraud Control Unit.
IMRP	Indiana Medical Review Program. Program administered by the IMF to insure the medical necessity of hospitalization and surgery.
indemnity insurance	Insurance product in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. See also *Fee-for-Service*.
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
inquiry	Type of online screen programmed to display rather than enter information. Used to research information about recipients, providers, claims adjustments and cash transactions.
institution	An entity that provides medical care and services other than that of a professional person. A business other than a private doctor or a pharmacy.
intensive care	Level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
interim	A billing that is only for a portion of the patient's continuous complete stay in an inpatient setting.
intermediary	Private insurance organizations under contract with the government handling Medicare claims from hospitals, skilled nursing facilities, and home health agencies.
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
IPA	Individual Practice Associate. Model HMO. A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
IPP	Individualized Program Plan.
IRS	Identical, related, or similar drugs, in relation to less than effective (LTE) drugs.
ISBOH	Indiana State Board of Health. Currently known as the Indiana State Department of Health (ISDH).
ISDH	Indiana State Department of Health. Previously known as Indiana State Board of Health.
ISETS	Indiana Support Enforcement Tracking System.

ISMA	Indiana State Medical Association.
itemization of charges	A breakdown of services rendered that allows each service to be coded.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.
Julian Date	A method of identifying days of the year by assigning numbers from 1 to 365 (or 366 on leap years) instead of by month, week, and day. For example, January 10 has a Julian date of 10 and December 31 has a Julian date of 365. This date format is easier and quicker for computer processing.
LAN	Local area network.
LCL	Lower Control Limit (Pertaining to quality control charts).
licensed practical nurse	LPN.
limited license practitioner	LLP.
line item	A single procedure rendered to a recipient. A claim is made up for one or more line items for the same recipient.
LLP	Limited license practitioner.
LOA	Leave of absence.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
location	Location of the claim in the processing cycle such as paid, suspended, or denied.
lock-in	Restriction of a recipient to particular providers, determined as necessary by the State.
lock-out	Restriction of providers, for a time period, from participating in a portion or all of the IHCP due to exceeding standards defined by the department.
LOS	Length of stay.
LPN	Licensed practical nurse.
LSL	Lower specification limit, pertains to quality control charts.
LTC	Long term care. Facilities that supply long-term residential care to recipients.

LTE	Less than effective drugs.
M/M	Medicare/Medicaid.
MAC	Maximum allowable charge for drugs as specified by the federal government.
managed care	System where the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuring quality in a cost efficient manner. See also *Section 1915(b), HMO, PPO, Primary Case Management.*
mandated or required services	Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services include the following: Hospital (IP & OP), lab/x-ray, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinic, certain nurse practitioners, federally qualified health centers, renal dialysis services, HealthWatch/EPSDT (under age 21), medical transportation.
manual claim	Claim for services submitted on a paper claim form rather than via electronic means; also seen as *paper* and *hard copy*.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCCA	Medicare Catastrophic Coverage Act of 1988.
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also *HMO, Prepaid Health Plan*.
MCPD	Managed Care for Persons with Disabilities. One of three delivery systems in the Hoosier Healthwise managed care program. In MCPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
MDS	Minimum data set.
Medicaid	A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.
Medicaid certification	The determination of a recipient's entitlement to Medicaid benefits and notification of that eligibility to the agency responsible for Medicaid claims processing.
Medicaid Financial Report	State Form 7748, used for cost reporting.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
Medicaid plan	See also *Medicaid State Plan, Single State Agency.*

Medicaid State plan	See also *Single State Agency, Medicaid Plan.*
Medicaid-Medicare eligible	Recipient who is eligible for benefits under both Medicaid and Medicare. Recipients in this category are *bought-in* for Part B coverage of the Medicare Program by the Medicaid Program.
medical emergency	Defined by the American College of Emergency Physicians as a medical condition manifesting itself by symptoms of sufficient severity that the abscence of immediate medical attention could reasonable be expected to result in: (a) placing health in jeopardy; (b) serious impairment to bodily function; (c) serious dysfunction of any bodily organ or part; or (d) development or continuance of severe pain.
medical necessity	The evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.
medical policy	Portion of the claim processing system whereby claim information is compared to standards and policies set by the state for the IHCP.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
medical supplies	Supplies, appliances, and equipment.
medically needy	Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.
Medicare	The federal medical assistance program described in Title XVIII of the Social Security Act for people over the age of 65, for persons eligible for Social Security disability payments and for certain workers or their dependents who require kidney dialysis or transplantation.
Medicare crossover	Process allowing for payment of Medicare deductibles and/or co-insurance by the Medicaid program.
Medicare deductibles and co-insurance	All charges classified as deductibles and/or coinsurance under Medicare Part A and/or Part B for services authorized by Medicare Part A and/or Part B.
mental disease	Any condition classified as a neurosis, psychoneurosis, psychopathy, psychosis or personality disorder.
mental illness	A single severe mental disorder, excluding mental retardation, or a combination of severe mental disorders as defined in the latest edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*.

mental retardation	Significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
menu	Online screen displaying a list of the available screens and codes needed to access the online system.
MEQC	Medicaid eligibility quality control.
MFCU	Medicaid Fraud Control Unit.
microfiche	Miniature copies of the RAs that can store approximately 200 pages of information on a plastic sheet about the size of an index card.
microfilm	Miniature copies of all claims received by Medicaid stored on film for permanent records-keeping and referral
misutilization	Any usage of the IHCP by any of its providers or recipients not in conformance with both state and federal regulations, including both abuse and defects in level and quality of care.
MLOS	Mean Length of Stay.
MMDDYY	Format for a date to be reflected as month, day, and year such as 091599.
MMIS	Medicaid Management Information System. Indiana's current MMIS is Indiana*AIM*.
MOC	Memoranda of Collaboration. For example, a Hoosier Healthwise document that provides a formal description of the terms of collaboration between a PMP and PHCSP, and serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
module	A group of data processing and/or manual processes that work in conjunction with each other to accomplish a specific function.
MRO	Medicaid Rehabilitation Option. Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.
MRT	Medical Review Team. FSSA Unit that makes decisions regarding disability determination.
MSW	Master of Social Work.
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.
NEC	Not elsewhere classified.

NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to online, real-time eligibility information.
Network Model HMO	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his or her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.
NF	Nursing facility.
NH	Nursing home.
NOC	Not otherwise classified.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
non-core services	Refers to *Service Packages #2 and #3*.
NOOH	Notice of Opportunity for Hearing. Notification that a drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the *Federal Register* on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications.
NPIN	National provider identification number.
nursing facilities	Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) Long Term Care Program. See also *Long Term Care, TILE.*
nursing facility waiver (NF waiver)	A waiver of the Medicaid's state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to adults as an alternative to nursing facility care. See also *Nursing Facilities, 1915(c), Waiver*.
OASDI	Old Age, Survivors and Disability Insurance. See also *Title II Benefits (Social Security or OASDI).*
OB/GYN	Obstetrician/Gynecologist.
OBRA	Omnibus Budget Reconciliation Act. Federal laws that direct how federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in such acts.
OCR	Optical Character Recognition Equipment. A device that reads letters or numbers from a page and converts them to computerized data, bypassing data entry.
OMNI	Point-of-sale device used by providers to scan recipient ID cards to determine eligibility.

OMPP	Office of Medicaid Policy and Planning.
optional services or benefits	More than 30 different services that a state can elect to cover under a state Medicaid plan. Examples include personal care, rehabilitative services, prescribed drugs, therapies, diagnostic services, ICF-MR, targeted case managed, and so forth.
OTC	Over the counter (in reference to drugs).
other insurance	Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.
other processing agency	Any organization or agency that performs Medicaid functions under the direction of the single state agency. The single state agency may perform all Medicaid functions itself or it may delegate certain functions to other processing agencies.
outcome measures	Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.
outcomes	Results achieved through a given health care service, prescription drug use, or medical procedure.
outcomes management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying, often in a formal program of continuous quality improvement.
outcomes research	Studies aimed at measuring effect of a given product, procedure, or medical technology on health or costs.
outlier	An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.
out-of-state	Billing for a Medicaid recipient from a facility or physician outside Indiana or from a military facility.
outpatient services	Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.
overpayment	An amount included in a payment to a provider for services provided to a Medicaid recipient resulting from the failure of the contractor to use available information or to process correctly.
override	Forced bypassing of a claim due to error (or suspected error), edit, or audit failure during claims processing. Exempted from payment pending subsequent investigation not to be in error.
overutilization	Use of health or medical services beyond what is considered normal.

PA	Prior authorization. Some designated Medicaid services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
paid amount	Net amount of money allowed by Medicaid.
paid claim	Claim that has had some dollar amount paid to the provider, but the amount may be less than the amount billed by the provider.
paid claims history file	History of all claims received by Medicaid that have been handled by the computer processing system through a terminal point. Besides keeping history information on paid claims, this file also has records of claims that were denied.
paper claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as *hard copy* and *manual*.
paperless claims	Claims sent by electronic means; equivalent to EMC, ECS, ECC, and similar terms denoting claim transmittal via electronic media.
parameter	Factor that determines a range of variations.
Part A	Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. See also *Medicare, Beneficiary*.
Part B	Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also *Medicare, SMIB, Buy-In*.
participant	One who participates in the IHCP as either a provider or a recipient of services.
participating providers	Providers who furnish Title XIX services during a specified period of time.
participating recipients	Individuals who receive Title XIX services during a specified period of time.
participation agreement	A contract between a provider of medical service and the state that specifies the conditions and the services the facility must provide to serve Medicaid recipients and receive reimbursement for those services.
PAS	Pre-admission screening. A nursing home and community-based services program implemented on January 1, 1987, that is designed to screen a recipient's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term-care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.

payouts	Generate payments to providers for monies owed to them that are not claim related. Payouts are done as the result of cost settlements or to return excess refunds to the provider.
PCA	Physician's Corporation of America. An HMO providing health benefits to Medicaid clients.
PCCM	Primary care case management. One of three delivery systems within the Hoosier Healthwise managed care program. Providers in PCCM are reimbursed on a fee-for-service basis. Recipients are assigned to a primary medical provider (PMP) or group that is responsible for managing the care of the recipient and providing all primary care and authorizing specialty care for the recipient—24 hours a day, seven days a week.
PCN	Primary care network.
PCP	Primary care physician. A physician the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.
PDD	Professional data dimensions.
PDR	Provider Detail Report/Provider Desk Review.
peer	A person or committee in the same profession as the provider whose claim is being reviewed.
peer review	An activity by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally-accepted standards.
pending (claim)	Action of postponing adjudication of a claim until a later processing cycle.
per diem	Daily rate charged by institutional providers.
performing provider	Party who actually performs the service/provides treatment.
PERS	Personal emergency response system, an electronic device that enables the consumer to secure help in an emergency.
personal care	Optional Medicaid benefit that allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living (for example, bathing, dressing, feeding, grooming). Indiana provides Primary Home Care Services under this option. See also *Primary Home Care*.
PGA	Peer group average.
PHC	Primary home care. Medicaid-funded community care that provides personal care services to over 40,000 aged or disabled people in Indiana. PHC is provided as an optional state plan benefit. See also *Personal Care*.
PHP	Prepaid health plan. A partially capitated managed care arrangement in which the managed care company is at risk for certain outpatient services. See also *VISTA*.

physician hospital organization	An organization whose board is composed of physicians, but with a hospital member, formed for the purpose of negotiating contracts with insurance carriers and self-insured employers for the provision of health care services to enrollees by the hospital and participating members of the hospital's medical staff.
plan of care	A formal plan developed to address the specific needs of an individual; links clients with needed services.
PM/PM	Per member per month. Unit of measure related to each member for each month the member was enrolled in a managed care plan. The calculation is as follows: # of units/member months (MM).
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to Medicaid recipients assigned to the PMP's care.
pool (risk pool)	A defined account (for example, defined by size, geographic location, claim dollars that exceed **x** level per individual, and so forth) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization. An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also *Exclusive Provider Organization (EPO)*.
PR	Provider relations.
practitioner	An individual provider. One who practices a health or medical service profession.
pre-payment review	Provider claims suspended temporarily for dispositioning and manual review by the HCE SUR Unit.
prescription medication	Drug approved by the FDA that can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.
preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care.
pricing	Determination of the IHCP allowable.
primary care	Basic or general health care traditionally provided by family practice, pediatrics, and internal medicine.
prime contractor	Contractor who contracts directly with the State for performance of the work specified.
print-out	Reports and information printed by the computer on data correlated in the computer's memory.

prior authorization	An authorization from the IHCP for the delivery of certain services. It must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances. Examples of such services are abortions, goal-directed therapy, and EPSDT dental services.
private trust	Trust fund available to pay medical expenses.
PRO	Peer review organization.
procedure	Specific, singular medical service performed for the express purpose of identification or treatment of the patient's condition.
procedure code	A specific identification of a specific service using the appropriate series of coding systems such as the CDT, CPT, HCPCS, or ICD-9-CM.
processed claim	Claim where a determination of payment, nonpayment, or pending has been made. See also *Adjudicated Claim*.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities needed to meet all federal Pro-DUR requirements and all DUR requirements.
profile	Total view of an individual provider's charges or a total view of services rendered to a recipient.
program director	Person at the contractor's local office who is responsible for overseeing the administration, management, and daily operation of the MMIS contract.
prosthetic devices	Devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb.
provider	Person, group, agency, or other legal entity that provides a covered IHCP service to an IHCP recipient.
provider enrollment application	Required document for all providers who provide services to IHCP recipients.
provider manual	Primary source document for IHCP providers.
provider networks	Organizations of health care providers that service managed care plans. Network providers are selected with the expectation they deliver care inexpensively, and enrollees are channeled to network providers to control costs.
provider number	Unique individual or group number assigned to practitioners participating in the IHCP.
provider relations	Function or activity within that handles all relationships with providers of health care services.
provider type	Classification assigned to a provider such as hospital, doctor, dentist.
PSRO	Professional standards review organization.

purged	Claims are removed from history files according to specific criteria after 36 months from the claim's last financial date. Claims data is online for up to 36 months.
QA	Quality assurance.
QARI	Quality Assurance Reform Initiative. Guidelines established by the federal government for quality assurance in Medicaid managed care plans.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QM	Quality management.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
QMHP	Qualified mental health professional.
QMRP	Qualified mental retardation professional.
quality improvement	A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement.
QUCR	Quarterly Utilization Control Reports.
query	An inquiry for specific information not supplied on standardized reports.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
RBA	Room and board assistance.
RBMC	Risk-based managed care. One of three delivery systems in the Hoosier Healthwise managed care program. In RBMC, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. The delivery system serves TANF recipients, pregnant women, and children.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
reasonable charge	Charge for health care services rendered that is consistent with efficiency, economy, and quality of the care provided, as determined by OMPP.

reasonable cost	All costs found necessary in the efficient delivery of needed health services. Reasonable cost is the normal payment method for Medicare Part A.
recidivism	The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.
recipient	A person who receives a IHCP service while eligible for the IHCP. People may be IHCP-eligible without being IHCP recipients. These individuals are called enrollees or members when in the Hoosier Healthwise Progam. See also *Client, Eligible Recipient.*
recipient relations	The activity within the single state agency that handles all relationships between the IHCP and individual recipients.
recipient restriction	A limitation or review status placed on a recipient that limits or controls access to the IHCP to a greater extent than for other nonrestricted recipients.
Red Book	Listing of the average wholesale drug prices.
referring provider	Provider who refers a recipient to another provider for treatment service.
regulation	Federal or state agency rule of general applicability designed and adopted to implement or interpret law, policy, or procedure.
reinsurance	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. See also *Stop-Loss Insurance*.
rejected claim	Claim determined to be ineligible for payment to the provider, contains errors, such as claims for noncovered services, ineligible provider or patient, duplicate claims, or missing provider signature. Returned to the responsible provider for correction and resubmission prior to data entry into the system.
related condition	Disability other than mental retardation which manifests during the developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (for example, self-care, expressive/receptive language, learning, mobility, self-direction, and capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other diagnoses, are said to be related to mental retardation in their effect upon the individual's functioning.
remittance advice (RA)	Comprehensive billing information concerning the recipient disposition of a provider's submitted IHCP claims.
Remittance and Status Report (R/A)	A computer report generated weekly to a provider to inform the provider about the status of finalized and pending claims. The R/A includes EOB codes that describe the reasons for claim cutbacks, and denials. The provider receives a check enclosed in the R/A when claims are paid.

rendering provider	A provider employed by a clinic or physician group that provides service as an employee. The employee is compensated by the group and therefore does not bill directly.
rep	Provider relations representative.
repayment receivables	Transaction established in the Cash Control System when a provider has received payment to which he was not entitled.
report item	Any unit of information or data appearing on an output report.
required field	Screen field that must be filled to display or update desired information.
resolution	Step taken to correct an action that caused a claim to suspend from the system.
resolutions	The area within the processing department responsible for edit and audit correction.
Retro-DUR	Retrospective Drug Utilization Review.
RFI	Request for Information.
RFP	Request for Proposals.
RHC	Rural health clinic.
RID	Recipient identification (ID) number; the unique number assigned to an individual who is eligible for Medical Assistance Programs services.
risk contract	An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also *MCO, Pool, Risk Pool*.
RN	Registered nurse.
RNC	Registered nurse clinician.
route	Transfer of a claim to a certain area for special handling and review.
routine	A condition that can wait for a scheduled appointment
RPT	Registered physical therapist.
rural health clinic	Any agency or organization that is a rural health clinic certified and participating under Title XVIII of the Social Security Act and has been designated by DHS as a Title XIX rural health clinic.
RVS	Relative value study. A procedure coding structure for all medical procedures, based on the most common procedure used, that assigns relative value units to medical procedures according to the degree of difficulty.
SBOH	State Board of Health. Previous term for the State Department of Health.

screening	The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive examination or treatment.
SD	Standard deviation.
SDA	Standard dollar amount.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
selective contracting	Option under Section *1915(b)* of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.
SEPG	Software Engineering Process Group.
service date	Actual date on which a service(s) was rendered to a particular recipient by a particular provider.
service limits	Maximum number of service units to which a recipient is entitled, as established by the IHCP for a particular category of service. For example, the number of inpatient hospital days covered by the IHCP might be limited to no more than 30 days.
SG	Steering group.
shadow claims	Reports of individual patient encounters with an MCO's health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.
SIPOC	System map outlining suppliers, inputs, processes/functions, outputs, and customers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SMI	Supplemental medical insurance, Part B of Medicare.
SNF	Skilled nursing facility.
SOBRA	Omnibus Budget Reconciliation Act of 1986.
SPC	Statistical process control.
special vendors	Provide support to IHCP business functions but the vendors are not currently Medicaid fiscal agents.
specialty	Specialized practice area of a provider.

specialty certification	Certification or approval by professional academy, association, or society that designates this provider has demonstrated a given level of training or competence and is a fellow or specialist.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.
spenddown	Process whereby Medicaid eligibility may be established if an individual's income is more than that allowed under the State's income standards and incurred medical expenses are at least equal to the difference between the income and the medically needy income standard.
SPMI	Severe and persistent mental illness.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSCN	Social security claim number. Account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is a social security account number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (for example, wife, widow, child, and so forth). The SSCN is the number that must be used in the Buy-In program. A beneficiary can have his own SSN but be receiving benefits under a different claim number.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
SSN	Social Security Account Number. The number used by SSA throughout a wage earner's lifetime to identify his or her earnings under the Social Security Program. This account number consists of nine figures generally divided into three hyphenated sets, such as 000-00-0000. The account number is commonly known as the Social Security Number. The number is not to be confused with Social Security Claim Number.
SSP	State Supplement Program. State-funded program providing cash asssistance that supplements the income of those aged, blind, and disabled individuals who are receiving SSI (or who, except for income or certain other criteria, would be eligible for SSI).
SSRI	Selective Serotonin Re-uptake Inhibitor
Staff Model HMO	Health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
standard business	Health care business within the private sector of the industry, such as Blue Cross and Blue Shield.
State	The state of Indiana and any of its departments, agencies, and public agencies.
State fiscal year	A 12-month period beginning July 1 and ending June 30.

State Medicaid Office — Office of Medicaid Policy and Planning, within the Family and Social Services Administration, responsible for administering the Medicaid program in Indiana.

State Plan — The medical assistance plan of Indiana as approved by the Secretary of Health, Education and Welfare in accordance with provisions of Title XIX of the Social Security Act, as amended.

status — Condition of a claim at a given time; such as paid, pended, denied, and so forth.

stop-loss insurance — Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance: (1) Specific or individual-reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as $25,000 or $50,000; (2) Aggregate-reimbursement is given for claims which in total exceed a predetermined level, such as 125 percent of the amount expected in an average year. See also *Reinsurance*.

subcontractor — Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.

submission — The act of a provider sending billings to EDS for payment.

subsystem — A Medicaid term that refers to one of the following (I)HIS processing components: recipient's subsystem, provider subsystem, claims processing subsystem, reference file subsystem, surveillance and utilization review subsystem, and management and administrative reporting subsystem.

SUR — Surveillance and Utilization Review. Refers to system functions and activities mandated by the CMS that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR requirements:

. statistical analysis
. exception processing
. provider and recipient profiles
. retrospective detection of claims processing edit/audit failures/errors
. retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards
. retrospective detection of fraud and abuse by providers or recipients
. sophisticated data and claim analysis including sampling and reporting
. general access and processing features
. general reports and output

suspended transaction — A suspended transaction requires further action before it becomes a paid or denied transaction, usually because of the presence of error(s).

suspense file — Computer file where various transactions are placed that cannot be processed completely, usually because of the presence of an error condition(s).

systems analyst/engineer	Responsible for performing the following activities:). Detailed system/program design l. System/program development 2. Maintenance and modification analysis/resolution 3. User needs analysis 4. User training support 5. Development of personal Medicaid program knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982. The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program.
TEFRA 134(a)	Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain disabled children.
therapeutic classification	Code assigned to a group of drugs that possess similar therapeutic qualities.
third party	An individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for, or recipient of, medical assistance under Title XIX.
third-party resource	A resource available, other than from the department, to an eligible recipient for payment of medical bills. Includes, but is not limited to, health insurance, workmen's compensation, liability, and so forth.
Title I	The Old Age Assistance Program that was replaced by the Supplemental Security Income program (SSI).
Title II	Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI).
Title IV-A	AFDC, WIN Social Services.
Title IV-B	Child Welfare.
Title IV-D	Child Support.
Title IV-E	Foster Care and Adoption.
Title IV-F	Job Opportunities and Basic Skills Training.
Title V	Maternal and Child Health Services.
Title X	Aid to the Blind program (AB) replaced by the SSI.
Title XIV	Permanently and Totally Disabled program (PTD) replaced by the SSI.

Title XIX	Provisions of Title 42, United States code Annotated Section 1396-1396g, including any amendments thereto.
Title XIX Hospital	Hospital participating as a hospital under Medicare, that has in effect a utilization review plan (approved by DHS) applicable to all recipients to whom it renders services or supplies, and which has been designated by DHS as a Title XIX hospital; or a hospital not meeting all of the requirements of Subsection A.5.1.0.0.0 of the RFP but that renders services or supplies for which benefits are provided under Section 1814 (d) of Medicare or would have been provided under such section had the recipients to whom the services or supplies were rendered been eligible and enrolled under part A of Medicare, to the extent of such services and supplies only, and then only if such hospital has been approved by DHS to provide emergency hospital services and agrees that the reasonable cost of such services or supplies, as defined in Section 1901 (a) (13) of title XIX, shall be such hospital's total charge for such services and supplies.
Title XV	ISSI.
Title XVI	The SSI.
Title XVIII	The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B); the provisions of Title 42, United States Code Annotated, Section 1395, including any amendments thereto.
TPL	Third Party Liability. A client's medical payment resources, other than Medicaid, available for paying medical claims. These resources generally consist of public and private insurance carriers.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services.*
TQM	Total Quality Management.
trend	Measure of the rate at which the magnitude of a particular item of date is changing.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UCL	Upper control limit, pertaining to quality control charts.
UCR	Usual, customary, and reasonable charge by providers to their most frequently billed nongovernmental third party payer.
unit of service	Measurement divisions for a particular service, such as one hour, one-quarter hour, an assessment, a day, and so forth.
UPC	Universal product code. Codes contained on the first data bank tape update and/or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
UR	Utilization review.

UR	Utilization Review. A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
urgent	Defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for the next day or a scheduled appointment.
user	Data processing system customer or client.
USL	Upper specification limits, pertaining to quality control charts.
utilization	The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.
utilization management	Process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.
VFC	Vaccines for Children program.
VFC	Vaccine for Children program.
VRS	Voice Response System, primarily seen as AVR, automated voice response system.
WAN	Wide area network.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children under 5 years old.
workmen's compensation	A type of third-party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which his employer's insurance company may be obligated under the Workman's Compensation Act.

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